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Focused Surrogate Decision-Maker Identification in the Traumatically Injured Adult

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,

and that any and all revisions required by

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Walden University

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MSN, University of Illinois, 2001

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Patients in the trauma care setting are often dependent on their families and physicians to decide medical treatments when they cannot participate in the process. But in up to one-third of cases, the surrogate decision-maker (SDM) selected by the patient is not the emergency contact listed in the electronic medical record (EMR). SDM identification and documentation will ensure that the patient is best represented by someone who knows their values and goals if they become incapacitated. Nurses can facilitate identifying a patient's SDM and document this choice in the EMR. The purpose of this study was a staff education program to improve intensive care unit (ICU) registered nurses' (RNs') knowledge of SDM identification. Adult learning theory informed the evidence-based education for ICU RNs regarding knowledge and technical instruction to identify and document the SDM in the EMR. A convenience sample of 32 ICU RNs were given staff education and a post-education survey to determine education effectiveness. The post-education surveys reflected highly positive scoring overall with opportunities for improvement on attention-grabbing and instructional methods. Then a pre- and post-chart audit tallied the number of before and after percentages of EMR documented SDM in the traumatically injured adult ICU population. The project increased the documentation of SDM from a pre-education level of 10% to post education level of 86%. This project contributes to social change by equipping ICU RNs with the knowledge to manage SDM identification and documentation to improve patient autonomy and decrease the social and medical burden on families, staff, and providers.

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Section 1: Nature of the Project

There is an established process in every U.S. state that allows a competent adult citizen to choose a surrogate decision-maker (SDM) for health care if they become unable to make decisions for themselves (Pope, 2017). This is often done through a legal document, commonly called a durable power of attorney for health care. This document is activated when the patient cannot make decisions and can be adapted to include specific restrictions such as not attempting to resuscitate, declining specialized treatments, and others. The document allows the named SDM to make health care decisions, including consenting and declining specific interventions as if the patient were making their own decision.

Identifying the presence of these documents or identifying no documented SDM is a critical first step in ensuring patient-centered and goal concordant care of the traumatically injured. Traumatically injured adults usually receive aggressive treatments due to uncertainty about the end outcomes following traumatic injury (Salottolo et al., 2015). Additionally, of those trauma patients admitted to the intensive care unit (ICU), 20% will die from their injuries (Geary et al., 2018). Without clear goals of care chosen by the patient or their SDM, patients may find their lives proceeding without regard to quality (Barkow, 1989) and lose their rights to be free from unwanted life-sustaining technology. These outcomes can have a direct impact on some of the most vulnerable members of society. Therefore, SDM identification and documentation impacts the understanding and sharing of a person's goals of care and treatment preferences (Walker

et al., 2018) and allow the individual patient to retain autonomy in their health care decisions (Vearrier, 2016).

Problem Statement

Patients in the trauma care setting are often dependent on their families and physicians to decide medical treatments when they cannot participate in the process. More than 71% of elderly ICU patients needed some sort of surrogate involvement within 48 hours of admission, often related to procedures and operations (Torke et al., 2014). However, some patients are incapacitated without access to family, friends, or a legal surrogate. In up to one-third of cases (Song & Ward, 2013), the eventual SDM selected by the patient was not the emergency contact listed in the EMR. Less than 25% of the patients have any SDM identification on admission (Torke et al., 2014). The rapid increase in the elderly trauma population and the advances in technology to treat the traumatically injured are expected to increase the need for SDM identification and documentation (Driesen, 2020).

SDM identification and documentation reduces the family and providers' decision-making burden and ensures concordant care with the patient's wishes (Dobbins, 2019). Early focused projects for SDM identification and documentation will ensure that the patient is best represented by someone who knows their values and goals if they become incapacitated. Identification upon admission of those patients who do not have SDM identified and documented will enable palliative, ethics, and social work mobilization. Nurses can facilitate identifying a patient's SDM and document this choice

in the EMR for access to other providers as they are in continuous contact with patients (Ryan & Jezewski, 2012).

A Midwestern Level 1 trauma urban hospital with 307 beds and 38 ICU beds had a 10–14% documentation of identified SDM in the EMR for discharged traumatically injured adults for two months preceding implementation of the educational project. A social work led project specifically for COVID-19 patients to identify and document SDM on admission to the emergency department was ongoing. This was an institutional imperative related to the no visitation policy on the COVID units. The severe limitations of family presence within the institution in general and the lack of palliative and social work resources revealed the gap in the identification and documentation of SDM in the trauma population. ICU registered nurses (RNs) were identified as a resource to assist in the SDM identification and documentation of the traumatically injured adult. The hospital has general educational topics, including videos about advance care planning, but none of these videos were specific to the identification and documentation of an SDM. A gap in ICU RNs' knowledge regarding SDM identification and documentation exists, which this project addresses.

Purpose Statement

Few studies have explored the knowledge gap of the trauma ICU RNs regarding SDM identification and documentation. Nevertheless, the literature suggested that RNs do not feel competent and lack knowledge regarding SDM identification and documentation (Bennett & O'Conner-Von, 2020). Prohibitions on family presence within the institution and low identification of SDM and documentation in the trauma population

require increased knowledge for ICU RNs regarding SDM identification and documentation to ensure patient-centered and goal concordant care. The purpose of this project was to explore the knowledge of ICU RNs regarding SDM identification and documentation after an educational program demonstrated by an increase in SDM documentation in the EMR 2 months after the education program. The practice question was, "Will a staff education program improve ICU RNs' knowledge of SDM identification, as demonstrated by an increase in SDM documentation in the EMR 2 months after the education program?"

Nature of the Doctoral Project

There is limited literature on SDM identification and documentation in the adult trauma population. Peer-reviewed English language articles were queried for the keywords *surrogate decision-maker*, *trauma*, and *nursing education* between 2015 and 2021 publication dates. Databases of peer-reviewed articles meeting criteria were obtained through CINAHL, EMBASE, ProQuest Nursing, Allied Health, Google Scholar, and PubMed.

Significance

Traumatic injury is increasing in prevalence in the geriatric population and its higher mortality and disability rates. More than 40% of patients require decision-making at the end of life, and 70% of those patients lack decision-making capacity (American College of Surgeons, 2016). In up to one-third of cases, the eventual SDM selected by the patient was not the emergency contact listed in the electronic health record (Song & Ward, 2013). Identification of SDM and EMR documentation of the patient's choice

involves several essential stakeholders. In addition to families and patients, the hospital organization is impacted by SDM documentation. Lack of an SDM can create conflict within families, problems with the goal of care, and potentially non-beneficial care. Society has a stake in the care of some of the most vulnerable members of society, such as the incapacitated elderly, the disenfranchised, and the unrepresented (Comer et al., 2018). Stakeholders will be impacted by addressing the knowledge gap regarding SDM identification and documentation.

Further, patient autonomy is an essential focus in health care delivery. Nursing's implications are reflected in the ANA Code of Ethics, which calls for nurses to ensure the patient's right to autonomy (Epstein & Turner, 2015). Addressing patient problems requires shared decision-making involving patients, families, providers, caregivers, organizations, and society (Hargraves et al., 2019). SDM identification and documentation will allow the stakeholders to provide patient goal-concordant care.

Potential contributions of the project to nursing practice also exist. Identification of an SDM with institutional assistance, if needed, would improve concordant goals of care and inform these goals to the selected surrogate. Understanding SDM identification and documentation will decrease compassion fatigue and moral distress related to the frustrations inherent in delivering care to patients who have not documented SDM (Mason et al., 2014).

Finally, the Patient Self-Determination Act (PDSA) of 1990 (Congress.gov, n.d.) was developed in response to potentially burdensome health care interventions and the costs of those interventions in the last months of life. The PSDA requires educational

programs for staff and the community concerning patient self-determination and advance care planning, and education is needed to ensure goal-concordant care. This project can be transferred to similar practice areas. The American Academy of Surgeons Trauma Quality Improvement Program Best Practice Guidelines provide recommendations regarding the seriously injured trauma patient's management (American College of Surgeons, 2017). Positive social change will occur for patients, families, caregivers, and the organization by equipping staff with the knowledge, skills, and competence to manage SDM identification and documentation.

Summary

Fewer than half of working RNs demonstrate knowledge regarding SDM identification and documentation (Miller, 2017). Early focused projects to identify and document the patient's choice of SDM will ensure that the patient is best represented by someone who knows their values and goals if they become incapacitated. Education regarding SDM identification and documentation positively affects RN knowledge (Hall & Grant, 2014). In this project, an RN educational project was evaluated through analysis of the increased number of SDM documentation of the traumatically injured adult in the EMR to assess the health care providers' knowledge regarding SDM identification and documentation. The practice question was, "Will a staff education program improve ICU RNs' knowledge of SDM identification, as demonstrated by an increase in SDM documentation in the EMR 2 months after the education program?"

Section 1 introduced the gap in practice, the purpose, and the significance of this project. The nature of the project was also described. Section 2 describes the model

framing this project, the evidence supporting the need for addressing the gap in practice, the context, and background for the project. My role and the role of the expert panel are also introduced.

Section 2: Background and Context

This project aimed to explore the knowledge of ICU RNs in identifying an SDM and documentation of the SDM in the EMR before and after an educational program. The practice question was, “Will a staff education program improve ICU RNs’ knowledge of SDM identification, demonstrated by an increase in SDM documentation in the EMR 2 months after the education program?” Section 2 describes Malcolm Knowles's theory of adult learning, the evidence supporting the project, the context and background, and the process of planning, implementing, and evaluating the project.

Concepts, Models, and Theories

Malcolm Knowles developed the concept of andragogy in 1968 as the “art and science of helping adults learn” (Merriam et al., 2006). He posited that adult learners are different from child learners in that adults need internal motivations to learn, adults bring prior experiences and knowledge, adult learners find relevance in learning that aligns with their reality, adult learners are self-directed, and adults need to know why they should learn. Andragogy incorporates these adult learner attributes to link to an educational experience recommending hands-on exercises and self-directed learning (Almeman & Alrebish, 2018). Andragogy has five key assumptions: the learner is independent, an individual’s experience is embraced, life’s challenges develop a readiness to learn, the learner is orientated to problem-centered applications, and the learner is driven by internal motivation (Merriam et al., 2006). Andragogy also encourages continual knowledge development, facilitates autonomy, bridges prior

knowledge, and teaches applicable content to solve real-world problems (Bennett et al., 2012).

ICU RNs are adult learners enmeshed in a high-intensity stressful environment and bring a wealth of previous knowledge to self-directed learning. The challenges of identifying and documenting the SDM in the traumatically injured adult requires problem-centered applications of knowledge and involve the intrinsic motivations ICU RNs have to attain practical and immediately useful knowledge to improve the care of their patients and the efficiency of the system. Andragogy is an adult learning concept that facilitates nursing knowledge construction. Table 1 aligns the five assumptions of this model with the project.

Table 1

Alignment of Adult Learning Theory to the Project

Assumptions	Application to Project
The learner is independent.	ICU RNs practice independently in their relationship with patients
An individual's experience is embraced.	ICU RNs have a wealth of experience in SDM concepts, and this project will enable those experiences to be incorporated into learning.
Life's challenges develop a readiness to learn.	Identifying and documenting an SDM provides challenges on a routine basis to ICU RNs. Knowledge regarding SDM identification and documentation can ease these common burdens.
The learner is interested in problem-centered applications.	Identification and documentation of SDM impacts daily work in the ICUs, and knowledge regarding mitigation of these subjects' issues is immediately applicable to daily routines.
The learner is driven by internal motivation.	Patient-centered care, family involvement and satisfaction, and concordant goal treatments are important motivators for ICU RNs, and knowledge regarding these concepts is needed.

Relevance to Nursing Practice

Autonomy

Autonomy is one of the four basic principles in health care ethics. Autonomy is defined as a person's capacity to self-govern and self-determine (Gillon, 2003); it is the patient's right to retain control over their body. Autonomy is also the main principle in the nursing code of ethics. Nurses are obligated to support the patients' medical wishes and advocate for a patient, including the patient's choice of SDM. When a patient designates an SDM, the patient exercises their right of autonomy. Identifying and documenting SDM is an essential method that nursing can ensure that patients' autonomy is represented if they can no longer make their own decisions. SDM identification is ideally performed by a patient able to make autonomous decisions and is best made after exploring the patient's values and desires and sharing the ideals and wishes with a trusted advocate. In cases where the patient has not been legally assigned or has not chosen a SDM, the decision-making usually follows state hierarchy statutes. Identifying and documenting an SDM when the patient can make independent choices is crucial to ensure they choose their SDM.

Patient Self-Determination Act

The PSDA was developed in response to potentially burdensome health care interventions and the costs of those interventions in the last months of life. Its goal was to ensure that patients' health care decisions were communicated and protected. Federal legislation requires health care institutions to provide information about advance health directives and their right to participate and direct their own health care decisions,

including refusing recommended treatments. The PSDA also requires organizations to document the patient's choice of SDM and inform patients that they have a right to have their goals of care known through the completion of advanced directives. SDM identification and documentation are essential components of patient assessment, and having concordant information regarding a patient's end-of-life care is a health priority (Folarinde & Alexander, 2017). Failure to address the patient's care goals and document in a readily accessible format, such as the EMR, may undermine their autonomy and create interventions and treatments potentially burdensome to the patients, families, and society.

The PSDA reflects the stereotypical U.S. culture of individual decision-making, autonomy, and traditional nuclear families. However, the PSDA, and most state laws regarding SDMs, may not reflect individual lifestyle choices not adhering to a nuclear family hierarchy (Hunsaker & Mann, 2013). The PSDA does not address those patients without family and no designated SDM, and most state laws default to family hierarchy without regard to the values and situation of the patient. The state laws of allowable surrogates when the patient result has not identified an SDM in health care delivery delays, moral and family distress as well as a violation of the patients' rights to self-determination when the hierarchy statutes fall without regard to the values and desires of the patient evidenced by their lifestyle choices (Comer et al., 2018).

Additionally, completion of SDM identification and documentation is frequently used to evaluate a hospital's advance care planning (ACP) system with relationship to the federal mandates outlined in the PSDA (Biondo et al., 2016), and ACP facilitated by a

professional is one strategy to strengthen patient autonomy and quality of care at the end of life (Klingler et al., 2016). Identification of the SDM is one of the first steps in producing an ACP document. Participants in ACP believe it is critical in an acute care setting (Hamayoshi et al., 2019). Still, fewer than half of working RNs demonstrate knowledge regarding SDM identification and documentation (Miller, 2017), and education is urgently required to strengthen ICU RN's knowledge (Biondo, 2016).

Unrepresented Patients

Patients in the trauma care setting are often dependent on their families and physicians to decide medical treatments when they cannot participate in the process. Some patients are incapacitated and alone—they have no friends, family, or legal surrogate. A growing population of patients lacks both capacity and an SDM on admission to the hospital. An estimated 70,000 unrepresented patients were admitted in 2017 (Sequiera & Lewis, 2017), with 16% of the patients admitted to an ICU being unrepresented (White et al., 2006). The time to treatment decisions and end-of-life care costs significantly increase in the unrepresented patient (Khan et al., 2015; Seetharaman & Gosula, 2017). Identification of this particularly vulnerable population is essential early in their trauma care.

Thirteen states have statutes related to the unrepresented patient, but the model is inconsistent with a specific statute (Godfrey, 2019). The number of patients who do not have identifiable surrogates is small, less than 1% over age 55, but is expected to grow (Godfrey, 2019). Still, the issue is common enough that the American Geriatrics Society has several recommendations regarding the unrepresented elderly patient (Farrell et al.,

2017). The society calls for uniform state statutes for SDM for these patients and proactive health care organizations to screen for the unrepresented before they cannot participate in their health care decisions. SDM identification and documentation will be an essential screening tool for these vulnerable populations in the trauma setting. Identification upon admission of those patients who do not have SDM identification and documentation will enable palliative, ethics, and social work mobilization.

RN Knowledge

The culture and environment in ICUs are complicated by critical decisions, stressful situations, and ethical challenges, further exacerbating decision-making conversations (Scholtz et al., 2016). The RN is particularly challenged because they work in an environment to provide life-saving treatment and may lack SDM identification and documentation knowledge. RNs also report unpreparedness when addressing SDM identification and documentation in ICUs (Kisorio & Langley, 2016). Nevertheless, these providers are present with the traumatically injured patients and their families, necessitating SDM identification and documentation (Jafari et al., 2015). Issues with SDM identification and documentation may be attributed to inadequate education. Thus, education regarding SDM identification and documentation positively affects RN knowledge (Hall & Grant, 2014). Communication skills training and role-playing training most consistently demonstrated significant improvements in outcomes for healthcare professional interventions (Walczak et al., 2016).

Local Background and Context

Hospitals are obligated, based on the PSDA 1990, to educate all adult patients on their right to accept or refuse medical treatment, to inquire on admission for the presence of SDM, and to educate their staff on the institution's policies and procedures regarding SDM (Hunsaker & Mann, 2013). If the patient is incapacitated, this information is provided to an individual's surrogate or family. In the traumatically injured adult population, patients can be severely injured and unable to voice medical care choices. Identification of the presence of a SDM is a critical step toward patient-centered and goal concordant care.

Despite the importance of SDM identification, a Midwestern Level 1 trauma urban hospital with 307 beds and 38 ICU beds had a 10–14% documentation of SDM in the EMR for admitted traumatically injured adults for two months preceding implementation of the educational project. No formalized structure was present for SDM identification and documentation before COVID-19 in the trauma population. Various employees performed SDM identification in urgent or emergent situations. A social work led project for the COVID-19 patients was ongoing to identify SDM on admission to the emergency department in response to the policy of no visitation on the COVID units. But because of the demand for staffing during the pandemic, the palliative care and social work teams do not have the resources to identify and document SDM on all populations admitted to the hospital. The severe limitations of family presence in the institution in general and the lack of palliative and social work resources revealed the gap in the identification and documentation of SDM in the trauma population.

Guidelines

The American Thoracic Society and the American Geriatrics Society (Pope et al., 2020) are resources for general policy statements regarding SDM in the ICU population. Recommendations include assessment of medical decision-making capacity in a systematic fashion (Farrell et al., 2016) and identification of an SDM within the first 24 hours (American College of Surgeons, 2017).

Definitions

Surrogate decision-maker (SDM): A person who makes health care decisions for a patient unable to make their own health care decisions. The SDM can be legally appointed as a legal guardian, appointed by the patient in a state-sanctioned document for durable power of attorney for healthcare, or assumed to have SDM authority based on common law or practice (Godfrey, 2019).

Role of the DNP Student

As a nurse practitioner who works in trauma in the organization, I have observed the lack of RN knowledge regarding SDM identification and documentation. My role for this project was to apply evidence-based recommendations in developing and implementing an education program for ICU RNs. I evaluated the education program and the 2-month post-data analysis using de-identified data provided by the institution.

Role of the Project Team

The expert panel consisted of the palliative care team and the trauma medical director. After Walden Institutional Review Board (IRB) approval, the expert panelists

reviewed the education program and the course evaluation before implementation. Recommendations for changes in the materials were completed before implementation.

Summary

Using the adult learning theory to address SDM identification and documentation, ICU RNs can increase their knowledge. The use of handouts, discussions and question-and-answer education at the point of care will increase SDM identification and documentation in the EMR. The practice question for this project was: “Will a staff education program improve ICU RNs’ knowledge of SDM identification, as demonstrated by an increase in SDM documentation in the EMR 2 months after the education program?” As health care providers become more aware of how their knowledge about SDM identification and documentation impacts the decisions made by patients and families, there may be an increase in RN’s knowledge. This knowledge may increase the possibility of clear patient chosen goals regarding healthcare. Section 3 includes an explanation of how evidence was collected and analyzed in the project study.

Section 3: Collection and Analysis of Evidence

Identifying patients who do not have an identified SDM documented in the EMR will enable palliative, ethics, and social work mobilization upon admission. The project's purpose was to measure changes in ICU RNs' knowledge of SDM identification and documentation following a staff educational program as evidenced by an improvement in SDM documentation in the EMR in the traumatically injured adult population. This doctoral project aimed to generate greater knowledge of SDM identification and documentation among ICU RNs in a large community hospital. Section 3 clarifies the practice-focused question, identifies the sources of evidence to address the practice-focused question, and describes how the evidence was collected.

Practice-Focused Question

The practice question for this project was "Will a staff education program improve ICU RNs' knowledge of SDM identification as demonstrated by an increase in SDM documentation in the EMR 2 months after the education program?"

Sources of Evidence

This project followed the steps in Walden University's staff education manual.

Planning

I met with organizational leadership to ascertain the educational needs of ICU RNs regarding SDM identification and documentation in the adult traumatically injured patient population. The hospital has several quality improvement projects to support specialized SDM identification and documentation in the adult trauma population. The

palliative care service line, spiritual care service line, ICU management, and trauma leadership participated in project planning discussions.

Implementation

Upon Walden IRB approval (approval no. 06-24-21-1037981), the expert panel reviewed the draft education program (Appendix B). I worked with organizational leadership to develop a schedule for the education handouts to be presented to all ICU RNs at staff huddles, occurring twice daily on the unit to capture day and night ICU RN schedules. Participants were given SDM identification and documentation information specific to the institution in a handout form (Appendix A). A concise hierarchy information reminder was available in work areas for the project's duration (Appendix D). Handouts with screenshots of the proper entry of SDM into the EMR were available at ICU computers. I provided discussion and question and answers support to the ICU RNs.

Evaluation

Participants were asked to complete the education program course evaluation (Appendix C) after the program. The anonymous program evaluations were handed out, collected, placed into a confidential folder up to 5 days after the program, and then analyzed.

Protection

A facility representative signed the site approval form for the staff education doctoral project from the staff education manual. The site approval form was submitted to the Walden University IRB for approval before implementing the project. Walden IRB

approval number was 06-24-21-1037981. Participants were given a consent form for anonymous questionnaires. Questionnaires were filled out without identifiable information and reported in aggregate.

Analysis and Synthesis

The course evaluation results from the trauma education program were analyzed using the percentage of completion. This data were reported to the stakeholders in aggregate to assist in future programs and further expansion into other adult inpatient populations. In addition, EMR completion of the SDM identifier documentation data from pre-education was compiled in aggregate and compared to the 2 months after the education program. SDM identifier data is tracked currently by the institution on a dashboard, and data from the adult traumatically injured population were compared pre- and post-education programs. At 2 months post educational program, the EMR documentation of an SDM in the traumatically injured adult were given a present or absent categorical value and were assigned a percentage of the population of traumatically injured adults admitted to the trauma ICU between September 1, 2021 and November 1, 2021. The results and recommendations were presented to organization stakeholders.

Summary

The project focused on ICU RNs' post-education knowledge of SDM identification and documentation within the admitted traumatically injured adult population. The participants were given education in handouts, question and answer discussion, screenshots of the method to input the SDM information into the EMR, and

quick bite sheets at point of care computers. The education course evaluation was provided after the staff education. The participants voluntarily participated in the education and the evaluation component. Aggregate dashboard data on SDM documentation in the EMR post-education were reviewed and compared 2 months before implementation.

Section 4: Findings and Recommendations

Fewer than half of working RNs demonstrate knowledge regarding SDM identification and documentation (Miller, 2017). Education regarding SDM identification and documentation can increase RN knowledge (Hall & Grant, 2014) and ensure that patients are represented by someone who knows their values. An RN educational project was used to assess the improvement in ICU RNs' knowledge on SDM documentation of the traumatically injured adult in EMRs.

Findings and Implications

The project involved a post-education evaluation of a convenience sample of ICU RNs present at four huddle meetings on different days to capture as many RNs as possible. The surveys were filled out anonymously by voluntary participants, and a total of 19 of 32 surveys were returned. Fourteen surveys were filled out completely, and five surveys were partially completed. Surveys were open to anonymous return for 5 days after the last staff education session.

The surveys consisted of a rating scale response (ranked 1 to 5 with 5 being the highest score) option and an area for an open response. The return of surveys was 75%, and the results of the incomplete surveys were calculated using only the available data. Table 2 includes the average scored ranking of the individual survey questions. The surveys reflect a highly positive scoring on most survey feedback with opportunities for improvement on attention-grabbing and instructional methods. The educational programs were provided at shift change team huddles to reach as many ICU RNs as possible, but

future programs may need to be given during a scheduled staff meeting or in small groups to avoid the change of shift timing.

Table 2

Average Survey Question Score

Survey Question	Average Score (Max of 5)
The content was interesting to me	4.59
The content extended my knowledge of the topic	4.35
The content was consistent with the objectives	5.00
The content was related to my job	4.70
Objectives were consistent with purpose/goals of activity	5.00
The presentation was clear and to the point	4.41
The presenter demonstrated mastery of the topic	4.76
The method used to present the material held my attention	3.88
The presenter was responsive to participant concerns	4.47
The instructional material was well organized	4.53
The instructional methods illustrated the concepts well	4.06
The handout materials given are likely to be used as a future reference	4.53
The teaching strategies were appropriate for the activity	4.59

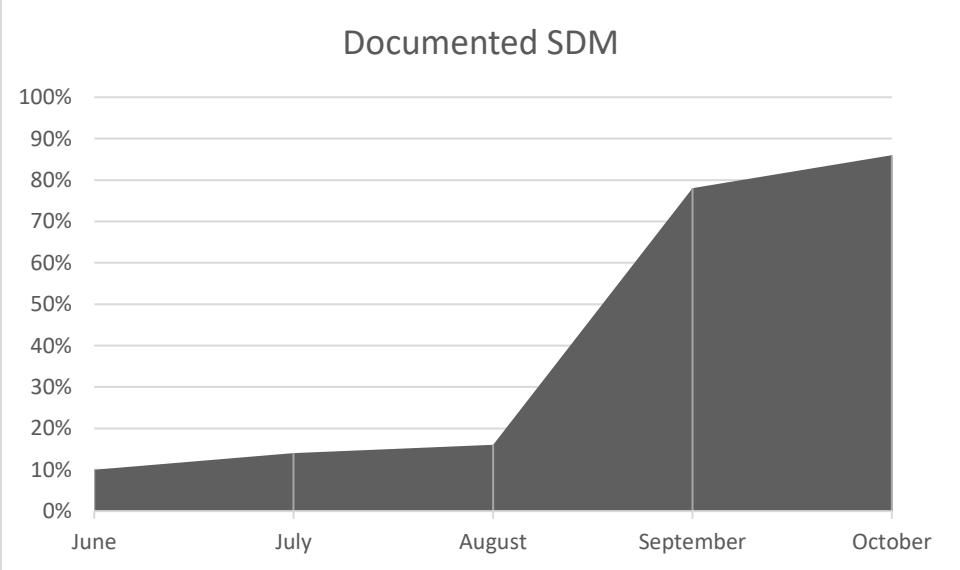
Results of the staff educational survey also included free-text comments. Comments included “the process on how to enter the data into EPIC was very helpful,” “this should be done on all ICU patients,” and “more information is needed on how to contact SW [social work] and CMS [case management].” In addition, two survey free-text comments were “lack of time” and “this should be done by intake admissions staff.” Further education will focus on social work contact information and numbers for assistance in completion for more complex situations such as the unrepresented patient and those patients with complex legal surrogates. The dedicated ICU trauma nurse

practictioner was the most significant resource in assistance, and most missed opportunities occurred on weekends where there was less support staff to assist.

Overall, the staff education had a significant impact on the documentation of SDM in the EMR, as seen in Figure 1. Dashboard evidence revealed that only 10%–14% of SDM identification occurred 2 months prior to the staff education. The percentage of SDM identification increased to 86% 2 months after the staff education.

Figure 1

Documented Surrogate Decision Makers



Recommendations

This project revealed that focused SDM identification in the traumatically injured adult is enhanced with staff education of ICU RNs. ICU nurses facilitate identifying a patient's SDM and document this choice in the EMR for access to other providers. Recommendations include using an adult learning theory-based program with evidence-

based information given in a format accessible to working ICU RNs. Based on the staff education surveys, including specific actions and contacts for more complex cases and broadening the application of the project to include all ICU patients is needed. Further study on the most appropriate format for education is also needed. The ICU RNs who participated in this education informally discussed their experiences and willingness to ensure all patients were prioritized to receive SDM identification. A dedicated champion for SDM identification should be identified to give follow-up education, monitor progress, and troubleshoot barriers to the process. SDM identification is a hospital-wide expectation, but the message and urgency required a visible content expert to champion the project.

Contribution of the Doctoral Project Team

The doctoral project team included palliative care, the trauma medical director, the trauma team, and the ICU RNs who care for the traumatically injured adult. Palliative care contributed systems knowledge and an operational dashboard for post-project analysis of traumatically injured adults admitted who had identified SDMs entered into the EMR system. The trauma medical director reviewed the relevant information and evidence from research to present the staff education project. The team validated the survey questions and gave input into the handouts. The trauma team compiled the dashboard data for documentation of the SDM in the EMR.

Strengths and Limitations of the Project

This project has several strengths and weaknesses. The sample was a convenience sample of ICU RNs who care for traumatically injured adults in a Level 1 trauma center.

The site has a strong palliative care presence, a dedicated trauma NP in the ICU, and significant institution cultural priorities regarding SDM identification and documentation. Informal discussions during the project described a clear benefit to the staff education project and the willingness of the ICU RNs to participate. Follow-up discussions with management revealed that the identification process of SDM is beginning to occur outside the trauma ICU population routinely.

A weakness of the project is that the staff education project may not be translatable to a different setting or institutional culture milieu. The institution where the staff education project took place has significant resources to meet SDM identification needs, impacting the post-staff education of SDM identification in the EMR. The palliative care team, three RN trauma patient coordinators, social work, spiritual care, and case management all can document SDM, and who entered the information was not recorded. Institutions with less support for SDM identification and documentation may have a lower improvement after ICU RN staff education. The number of surveys returned was 75% (19 out of 32 surveys). The number of returned surveys was lower than expected and is likely related to time constraints and significant turnover of base nursing staff. The traumatically injured adults are in one of three ICU units, and not all ICU RNs who attended the staff education work with the trauma population. It is difficult to determine if a trauma nurse practitioner on the unit influenced SDM identification and documentation improvements in the EMR. However, it can be assumed to have an impact since most missed opportunities for SDM identification occurred on weekends when the ICU dedicated trauma nurse practitioner was not on site.

Section 5: Dissemination Plan

DNP projects influence health care outcomes at the population level and are essential in leading change toward improved clinical practice (Turkson-Ocran et al., 2020). Dissemination of new knowledge gained from DNP projects is essential in the uptake, success, and sustainability and should inform, raise awareness, and promote the knowledge. This project will be disseminated to the priority organization in several ways. The results will be presented to the stakeholders during scheduled staff meetings. The meeting PowerPoint presentations will be arranged with the trauma medical director and trauma team, the intensive care nurses and management, and palliative and spiritual care. Showing results of the education project will allow for application to a broader range of service lines and patient populations such as the general trauma service, the medical ICU, and others. The accrediting body for trauma surgery will receive the project results as a more comprehensive quality improvement project.

Analysis of Self

This DNP project journey combined my role as a practitioner, project manager, scholar, leader, and mentor. My interest in SDM identification in the trauma population comes from years of experience in poor patient outcomes I have identified as having opportunities for focused improvements. I was able to take an identified need and critically appraise the evidence for this practice change. Managing the project required stakeholder identification and engagement as well as the assumption of a leadership role. The project manager and leadership roles required professional collaborations, which will strengthen my future projects. The stakeholders remain a part of the project as it moves

forward and becomes a sustainable cultural change. I was able to mentor ICU RNs in trauma who will continue to support their colleagues and train new nurses in identifying surrogates in the trauma population. The most impactful component of the DNP project journey was in my role as a scholar. Utilizing theories and a framework to organize the project has given me an infrastructure to take forward in my career and contribute to the nursing body of knowledge for improvement in population health.

Summary

SDM identification and documentation impacts the understanding and sharing of a person's goals of care and treatment preferences (Walker et al., 2018) and allows the individual patient to retain autonomy in their healthcare decision (Vearrier, 2016). Identifying the presence of these documents or identifying no documented SDM is a critical first step in ensuring patient-centered and goal concordant care of the traumatically injured adult. This project focused on ICU RNs' pre- and post-education knowledge of SDM identification and documentation in the admitted traumatically injured adult population. The education program improved the RNs' knowledge, as evidenced by the post-education SDM identification and documentation from 10% before education intervention to 86% post-education. Further research should focus on the optimal educational format, a plan for follow-up training, and the impact of content expert and practice milieu in this educational project.

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Appendix A: Next of Kin Hierarchy

Focused Surrogate Identification in the Traumatically Injured

Please identify the surrogate decision-maker (SDM) on all trauma patients and document their name and number. Check the ACP section box for "primary decision-maker" as appropriate.

Do they have a legal guardian?

Yes. STOP. This person is their SDM. Call medical records to upload document.

No.

Do they have a legal Durable Power of Attorney for Healthcare?

Yes. STOP. This person is their SDM. Call medical records to upload document.

No.

Are they legally married?

Yes. STOP. This person is their SDM.

No.

Do they have adult children?

Yes. Efforts must be made to contact all adult children.

No.

Do they have legal parents?

Yes. Efforts must be made to contact all parents.

No.

Do they have legal brothers and sisters?

Yes. Efforts must be made to contact all adult siblings.

No.

Consult social worker to identify legal next of kin.

Appendix B: Education Program

Participants will include ICU RNs who care for a traumatically injured adult.

1. What is a surrogate decision-maker?
    a. Surrogate decision-maker (SDM) - a person who makes healthcare decisions for a patient unable to make their own decisions.
2. What is the benefit of identifying the SDM?
    a. Enables the patient to keep autonomy in decision making if they become incapacitated.
    b. Ensures goal concordant care- SDM ideally is chosen by the patient and knows their wishes or will act in the patient's best interests.
3. What are the disadvantages of not having an identified SDM?
    a. Patient wishes are not known or followed.
    b. Locating next of kin delays decisions, and family hierarchy can be complicated.
    c. Family conflict regarding decision making, multiple opinions delaying or prolonging care.
    d. Patient, family, and staff distress related to SDM issues.
    e. Potentially non-beneficial treatments are undertaken due to lack of SDM.
4. Who decides if there is no SDM and the patient is incapacitated?
    a. Legal guardian takes precedence.
    b. Ohio state hierarchy is followed if no legally appointed SDM.
        i. Spouse if not legally separated
        ii. All legal adult children
            1. Adult children majority
            2. Reasonable efforts must be made to contact each legal child.
        iii. Parents
        iv. All adult siblings
            1. Adult sibling majority
            2. All reasonable efforts must be made to contact each legal sibling.
        v. Continues to next of kin in a hierarchal fashion.
5. What happens if the next of kin defer decisions to another?
    a. Must be hierarchal deferral.
        i. Can only defer to next of kin.
            1. Example- cannot defer to significant other or friend.
6. When should social work be called?
    a. Call social work to locate next of kin if not readily available.
    b. Call social work if identifying next of kin is required.
    c. Call social work as needed to assist in establishing legal SDM.
7. How is the SDM documented in EPIC?

a. Click on the “code status” link.
b. Find emergency contact list.
c. Enter kin name and phone number.
d. Choose “PRIMARY DECISION MAKER” and “ACTIVE” for the legal SDM.
e. Write a note under APC as indicated.

Appendix C: Program Evaluation

EDUCATION EVALUATION FORM

As a learner, please assist in the evaluation of this presentation. Please circle the number beside each statement that best reflects the extent of your agreement. Thank you.

		Disagree			Agree
Content					
1.	The content was interesting to me.....	1	2	3	4 5
2.	The content extended my knowledge of the topic.....	1	2	3	4 5
3.	The content was consistent with the objectives.....	1	2	3	4 5
4.	The content was related to my job.....	1	2	3	4 5
5.	Objectives were consistent with purpose/goals of activity.....	1	2	3	4 5
Faculty/Presenter Effectiveness					
6.	The presentation was clear and to the point.....	1	2	3	4 5
7.	The presenter demonstrated mastery of the topic.....	1	2	3	4 5
8.	The method used to present the material held my attention.....	1	2	3	4 5
9.	The presenter was responsive to participant concerns.....	1	2	3	4 5
Instructional Methods					
10.	The instructional material was well organized.....	1	2	3	4 5
11.	The instructional methods illustrated the concepts well.....	1	2	3	4 5
12.	The handout materials given are likely to be used as a future reference.....	1	2	3	4 5
13.	The teaching strategies were appropriate for the activity.....	1	2	3	4 5

Learner Achievement of Objectives

Discuss the importance of identifying the SDM

Identify the hierarchy of SDM

Indicate the process of EMR documentation of SDM

Comments:

Appendix D: Concise Hierarchy Information

Stepwise order of Ohio hierarchy for surrogate decision-makers